Board of Directors Meeting Report

Subject: **Board Assurance Statement**

Date: **27th March 2014**

Author: **KERRY ROGERS, DIRECTOR OF CORPORATE SERVICES/COMPANY SECRETARY**

Lead Director: **KERRY ROGERS**

EXECUTIVE SUMMARY

Foundation Trusts are required, as part of the Annual Report and Accounts, to prepare an Annual Governance Statement, for which a model form is provided and attached at the back of this report. The Trust is required to adapt the model and expand upon it, to reflect our own particular circumstances retaining the necessary text as prescribed in the Financial Reporting Manual.

To support the signing of the AGS, the Company Secretary has introduced a Board Assurance Statement which will in future be presented to Board twice a year (March and September) to inform the assurances required in order to confidently recommend to the Accounting Officer, that he sign the AGS on behalf of the Board. This is the first of the new Board Assurance Statements intended to evidence the work of the Board across the year in reviewing the effectiveness of internal controls, to gain assurance and to test governance processes that have been established in the organisation across the whole year. These statements should support self-certifications to the regulators and, most importantly, support the annual Board declaration concerning the systematic review / testing of key controls in the form of the Annual Governance Statement – and ensure that the AGS is not perceived by the Board to be a 'once a year' action.

Through reading the document it should evoke a number of questions for Board members to ask themselves about the arrangements they have (and have had) in place and the assurances they are provided with not only to support preparation and sign off of the Annual Governance Statement, but also to enable members to develop or evolve our governance arrangements in a way which effectively supports achievement of our organisation's strategic objectives and improves our approach to risk and quality management.

Part of the Annual Report submission also obligates against the 'comply or explain' principal, that the Trust explains reasons for any non-compliance with Monitor's Code of Governance and illustrates how its actual practices are consistent with the principle to which the particular provision relates. When the draft AGS goes to Audit and Assurance committee in April, the Code of Governance statements will be included for consideration.

When the AGS is presented to Audit and Assurance Committee in April it will record the stewardship of the organisation to supplement the accounts. It will give a sense of how successfully it has coped with the challenges it faced and of how vulnerable performance is or might be. This statement will draw together position statements and evidence on governance, risk management and control, to provide a coherent and consistent reporting mechanism.

The BAS has been introduced simply because the governance statement should be a 'live' document reflecting the organisation's governance procedures and systems. It should not be produced through a process designed solely for the annual report and accounts as a once a year procedure. The governance statement should refer to the board's committee structure, the board's performance, including its assessment of its own effectiveness and to ensuring that required standards are achieved.
All elements of the governance statement are important, however, the risk assessment is critical. This is where the accountable officer supported by the board should discuss how the organisation's risk management and internal control mechanisms work. Where there are weaknesses, the emphasis should be on how these have been addressed. Where there have been reports published on the organisation during the year, the AO should reflect on the assurance these provide in helping to achieve effective operation of controls.

The organisation's external auditor (KPMG) will review the governance statement and will report on:

• inconsistencies between information reported in governance statements and their knowledge of the audited body (the Trust); and

• any failure to comply with Monitor requirements.

ACTIONS REQUIRED BY BOARD

Board members are invited to:

- Consider if this Statement substantiates the evidence that will be required to support signing of the Annual Governance Statement (AGS) by the Accounting Officer on behalf of the Board, as part of the Annual Report and Accounts submission process.

- The Board of Directors is invited to continually consider the detailed content of the six-monthly Board Assurance Statements in assuring it of the effectiveness of the Trust's management of risk and the effective operation of controls in order to offer credibility and robustness to Board's self-assessments to the Regulators and Board is reminded of the importance of deliberations regarding the seriousness in terms of 'significance' of control failures / weaknesses in support of the AGS submission as part of the Annual Report (as detailed in section *6. Significant Control Issues*).

- A draft of the Annual Governance Statement for inclusion in the Annual Report will be presented to the April Audit and Board meetings.

- Board Committee chairmen should consider how the work of their Committees might better support assurance of the effectiveness of internal controls and ensure they drive the agendas accordingly.

Relevant Strategic Objectives (please mark in bold)	
Achieve the best patient experience	**Achieve financial sustainability**
Improve patient safety and provide high quality care	Build successful relationships with external organisations and regulators
Attract, develop and motivate effective teams	
Links to the BAF and Corporate Risk Register	Board and its Committees are responsible for the systematic review of the trust's control environment
Details of additional risks	n/a
Links to NHS Constitution	n/a
Financial Implications/Impact	n/a
Legal Implications/Impact	n/a
Partnership working & Public Engagement Implications/Impact	n/a
Committees/groups where this item has been presented before	n/a

Annex 6 to Chapter 7: Model Annual Governance Statement

[The wording which is not in square brackets in this pro forma annual governance statement (AGS) should be replicated in every AGS and the words in square brackets should be amended and expanded as appropriate to the body in question.]

Scope of responsibility
As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of [insert name of provider] NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in [insert name of provider] NHS Foundation Trust for the year ended 31 March 20xx and up to the date of approval of the annual report and accounts.

Capacity to handle risk
[Describe the key ways in which:

- leadership is given to the risk management process; and
- staff are trained or equipped to manage risk in a way appropriate to their authority and duties. Include comment on guidance provided to them and ways in which you seek to learn from good practice.]

The risk and control framework
[Describe the key elements of the risk management strategy, including the way in which risk (or change in risk) is identified, evaluated, and controlled. Include mention of how risk appetites are determined. Explicitly describe the key elements of the quality governance arrangements, including how the quality of performance information is assessed and how assurance is obtained routinely on compliance with CQC registration requirements. Explicitly include how risks to data security are being managed and controlled as part of this process. Include a brief description of the organisation's major risks, including significant clinical risks, separately identifying in-year and future risks, how they are/will be managed and mitigated and how outcomes are/will be assessed.]
[***Include a description of the principal risks to compliance with the NHS foundation trust condition 4 (FT governance) and actions identified to mitigate these risks, particularly in relation to:***

- ***the effectiveness of governance structures,***
- ***the responsibilities of Directors and subcommittees;***

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- ***reporting lines and accountabilities between the board, its subcommittees and the executive team;***

- ***the submission of timely and accurate information to assess risks to compliance with the trust's licence; and***

- ***the degree and rigour of oversight the board has over the trust's performance.]***

[***Describe the key ways that the trust is able to assure itself of the validity of its Corporate Governance Statement, required under NHS foundation trust condition 4(8)(b)]***

[Describe key ways in which risk management is embedded in the activity of the organisation. For example, set out the ways in which equality impact assessments are integrated into core trust business or how incident reporting is openly encouraged and handled across the trust.]

[Describe the key elements of the way in which public stakeholders are involved in managing risks which impact on them.]

The foundation trust is fully /is not fully compliant with the registration requirements of the Care Quality Commission.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources
[Describe the key process that has been applied to ensure that resources are used economically, efficiently and effectively, including some comment on the role of the board, internal audit and any other review or assurance mechanisms.]

[Brief description of steps which have been put in place to assure the board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data

These steps would cover areas such as:

- governance and leadership (including processes to ensure the Quality Report presents a balanced view);

- ***the role of*** policies and ***plans in ensuring quality of care provided***;

- systems and processes;

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- people and skills; and
- data use and reporting (comments on the systems in place to review and report the quality metrics, ***focusing on both data collection and reporting***)]

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Review of effectiveness
As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee [and risk/ clinical governance/ quality committee, if appropriate] and a plan to address weaknesses and ensure continuous improvement of the system is in place.

[Describe the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, including some comment on the role and conclusions of:

- the board;
- the audit committee;
- if relevant, the risk/ clinical governance/ quality committee/risk managers/risk improvement manager;
- clinical audit;
- internal audit; and
- other explicit review/assurance mechanisms.

Include an outline of the actions taken, or proposed to deal with any significant internal control issues and gaps in control, if applicable.]

Conclusion
[state either that no significant internal control issues have been identified or make specific reference to those significant internal control issues which have been identified in the body of the AGS above]

Signed………………..

Chief Executive Date:

xx June 20xx

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Sherwood Forest Hospitals NHS Foundation Trust

Board Assurance Statement March 2014

Authors	
Kerry Rogers	**Director of Corporate Services and Company Secretary**

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1. Background

1.1 As a public benefit corporation, the Trust needs to be held to account for its actions, decision-making and ultimately the achievement of its purpose and objectives. Good governance is essential to the achievement of strategic objectives. The governance arrangements within the organisation should focus on ensuring the achievement of the strategic objectives through effective performance & quality management and risk management.

1.2 Strong governance arrangements create a framework for providing the Board with sound assurances in relation to the achievement of the objectives, which in turn enables Board to be confident at all times about the current position. Since 2001/2 all NHS Chief Executives (Accounting Officers) have been required to sign an Annual Governance Statement (previously the Statement on Internal Control) as part of the statutory accounts and annual report, indicating that they were fully acquainted of the current position of the organisation.

1.3 This document - the **Board Assurance Statement** has been introduced by the Director of Corporate Services/Company Secretary and will in future be presented to Board twice a year (March and September) to inform the assurances required in order to confidently recommend to the Accounting Officer, that he sign the AGS on behalf of the Board. This is the first of the new Board Assurance Statements intended to evidence the work of the Board across the year in reviewing the effectiveness of internal controls, to gain assurance and to test governance processes that have been established in the organisation across the whole year. These statements should support self-certifications to the regulators and, most importantly, support the annual Board declaration concerning the systematic review / testing of key controls in the form of the Annual Governance Statement – and ensure that the AGS is not perceived by the Board to be a 'once a year' action.

1.4 Through reading the document it should evoke a number of questions for Board members to ask themselves about the arrangements they have in place and the assurances they are provided with not only to support preparation and sign off of the Annual Governance Statement, but also to enable members to develop or evolve our governance arrangements in a way which effectively supports achievement of our organisation's strategic objectives.

2. The Purpose of the System of Internal Control

2.1 The system of internal control is designed to manage risk and performance to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based **on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives** of Sherwood Forest Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. **As part of the Annual Governance Statement, the Trust is required each year to state that the system of internal control has been in place for the year ended 31st March and up to the date of approval of the annual report and accounts.**

2.2 The Board must understand its obligation to ensure that the organisation complies with its own governing documents – the Constitution and Authorisation/Licence, with relevant laws and with the requirements of regulatory bodies, standing orders, standing financial instructions and scheme of delegation. A review of the Constitution, Standing Orders, Standing Financial Instructions and Reservation of Powers/Scheme of Delegation has commenced, and amendments will be presented for approval by the Board in the coming months. Complimentary

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amendments to the Scheme of Delegation will also incorporate the Committee restructure and will form part of the final approvals by the Board. The Board is aware that the Health & Social Care Act 2012 has necessitated mandatory changes to the Trusts' governing documents. A specially convened working group (comprising both governors and the Company Secretary) has concluded a review of the Constitution and the proposed changes for final presentation to the Board and to Council are currently being considered by the lawyers and a briefing was sent to the February Board of Directors meeting.

In order to meet the statutory requirements, but importantly for the Board of Directors to be confident in its self-certifications, the Board needs to be assured of the validity of information and the effectiveness of systems that ensure compliance as a minimum with mandatory and best practice frameworks to include:

- All relevant laws and the requirements of Monitor through Board's understanding of the processes supporting compliance. To formalise a process to assure Board of compliance going forwards, the Company Secretary will be working with her newly appointed Deputy to introduce to the Trust a Compliance Framework that will systematise self-assessment of compliance with mandatory frameworks across the Trust and provide clear line of sight for the Executives and Board of areas of potential non compliance.
- The requirements of and the Trust's compliance with, the Care Quality Commission, Department of Health, NHS Litigation Authority, NICE, Safety alerts and others - through the Board's understanding of the process adopted to reach a declaration of compliance illustrated in particular within the relevant reports received through the Quality reporting process, the Corporate and Legal services reports and the Patient Experience Reports, coupled with the confidence in the role of Committees in determining compliant status.
- Health & Safety legislation – through the quarterly patient and staff quality/HR reports and annual H&S report;
- External agency requirements – in the absence of a formal route for the outcome of all such visits, to formalise line of sight of TMB and Board of Director members the Company Secretary has developed a policy for External agency visits; inspections and accreditations to be discussed at April's TMB which will be operationalized during 14/15 to ensure readiness for, and understanding of the outcome of external reviews providing clear line of sight of Board and Executives of successes and potential risk areas.
- Any other legislation or regulation which may apply concerning such as conditions on the Trust's Licence to operate - through the workplans of the Clinical Governance & Quality, Audit and Finance & Performance Committees of the Board.
- The effectiveness of Service Line, Division and Corporate/Business - clinical and corporate governance and risk management practice.

2.3 As stated above, there does not currently exist in the Trust a robust, formal and systematic process for assessing compliance against existing, new or changing legislation or best practice. As a consequence, the Company Secretary, as part of her work to define the Assurance Framework for the Trust is working on implementation of a Compliance Directory, which would comprise of registries for consultations, new and revised regulation and legislation and counter fraud alerts with exception reports provided to Quality Committee every other month. A robust approach to spot checking of items included on the compliance directory would also eventually be introduced to enable areas of concern to be identified and rectified by undertaking regular spot checks of the Compliance Directory to strengthen the clinical directorates' approaches to self-assessment of compliance. None of this is to say that the Trust is not in compliance, this is merely to systematise the process of ensuring and assuring compliant status, ensuring ownership and responsibility for self-assessments of compliance and the monitoring of any necessary action plans to deliver compliance or address non-conformity notices, and to introduce independence to assessment of complaint status.

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Training would be undertaken to implement or to strengthen any, existing systems designed to ensure Service departments remain compliant with legislation and regulations alongside the creation of a 'Departmental Compliance Directory Standard Operating Procedure (SOP)' This SOP would provide guidance to all Heads of Department as to how they should log new / revised legislation, regulation or Royal College guidance for instance, pertinent to their own department onto Datix as well as how to create an action plan to ensure compliance and upload evidence of compliance onto Datix and cross reference to any relevant risk assessments or risk register entries. An evaluation of the extent to which the SOP had been implemented across the Trust would also form part of the Assurance Framework and methodology.

In the absence of such a process (merely serving to centralise and operationalise this intelligence), Board members will need to rely on Board Reports, walk-around visits, confirm and challenge sessions and the work of their Committees across the preceding year in order to satisfy themselves of compliance across such mandatory/best practice contexts.

2.4 The Internal Audit operational plan for 2013/14 was approved by the Audit Committee at the beginning of 2013 and regular reports against the plan have been presented to the Audit Committee. A snapshot of the annual programme and resulting findings, which have been monitored by the Audit committee are provided later in the report to enable Board members to satisfy themselves of the depth and scope of control testing across the Trust providing independent assurance of control effectiveness.

3. Capacity to Handle Risk

3.1 *The AGS requires that the Trust describes key ways in which*

- *Leadership is given to the risk management process, and*
- *Staff are trained or equipped to manage risk in a way appropriate to their authority and duties. We are encouraged to include comment on guidance provided to them and ways in which we seek to learn from good practice.*

3.2 The Foundation Trust's Board of Directors provides leadership and a high level of commitment for establishing effective risk management systems across the Trust. The Chief Executive has overall accountability for the management of risk by the Trust and responsibility for specific risk management areas, has been delegated to the Trust Executive.

Throughout the year, The Risk Management Framework (review date due Feb 2013) is the relevant strategy that has been in operation within the Trust, and is currently being revised by the Interim Risk Manager and the draft which is now ready for wider consultation is included on the March Board agenda, and identifies the organisation's approach to risk, the executive and non-executive director roles and responsibilities and the structure in place for the management of risk. The strategy contains a clear definition of risk and the scope to handle risk has been supported by the Company Secretary and will transfer to the Director of Nursing from April 2014, when the role will integrate with the focus on compliance and risk (to delivery of quality etc) within the dedicated Governance Support Unit. The strategy clarifies individual and collective responsibility for risk management from the Board of Directors through to all staff within the organisation. It sets out the Trust's attitude to risk and includes guidance on risk identification, risk assessment, risk scoring and risk monitoring as well as outlining the agreed principles for effective risk management within the Trust along with clarity of roles of the Committees and sub-committees which support the Trust Management Board (TMB) sub structure.

A range of risk management training has been provided to staff since November last year which from the extensive written and emailed feedback has been very well received, and there are policies in place to describe staff roles and responsibilities in relation to the identification

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and management of risk. The revised Risk Management strategy will need to be approved by Board of Directors at a future meeting, and, following consultation will be scheduled for review annually. A job description for a substantive Risk Manager is currently being A4C job matched and the recruitment process will commence imminently.

The Trust has many opportunities to learn from good practice through a range of mechanisms including clinical supervision, individual and peer reviews, performance management, professional development, clinical audit and application of evidence based practice and root cause analysis and the learning coming out of complaints, incidents and inquests/claims. The effectiveness of those processes will need to be understood by the Board and will need to be more robustly tested going forwards through the Board Committee structure, but it is understood that as the Governance Support Unit completes its restructure, a much greater emphasis is to be put on formalising an organisational understanding of the learning from the things we haven't done so well in order to mitigate against recurrence.

In December, the Company Secretary introduced a 'True for Us' programme, to ensure the Trust assesses its own situation against such as high profile failures / inquires (e.g. the Francis report) and cross industry best practice (e.g. industry failing outside the NHS). This work will be progressed as her team develops, over the coming months to ensure there is a process to capture such opportunities from which to learn.

The Board receives, on a monthly and quarterly basis, the Quality and Integrated Performance reports which detail any issues and improvements relating to both patients and staff collated from incident data, complaints / concerns, mortality reviews and other data sources and includes narrative regarding quality issues and staff training relating to the safety, experience and quality agenda. Key new actions and learning are highlighted within the reports and Board members will need to be confident they understand that such actions have been implemented and are sustained.

The Board will need to ensure that it has confidence in the processes that support learning and will need to consider future requirements to better understand information on the organisation's response to safety alerts received via such as the Central Alert System (CAS) and the Company Secretary is ensuring that such are a prominent feature on the agenda of the new Quality Committee Below is a record of the safety alerts received and registered in MEMD. The process has during the year included involvement of CMT in determining compliant status and declaration of such outside the Trust, providing affirmation externally the Trust has complied with the notice in the required timescales. The Company Secretary is looking to strengthen the process of determination of compliance with such safety alerts to increase confidence in the declaration of compliance being made to bodies/regulators outside the Trust and will also work with the GSU and will ensure the strengthened process aligns with the plans outlined regarding the External Recommendations Policy to offer greater line of sight of the full Executive team.

CAS SFHFT Safety Alert Status 5/3/14

Reference	**Alert Title**	**Originated By**	**Issue Date**	**Response**	**Deadline**
PSA/D/2014/002	**Non-Luer spinal devices for chemotherapy**	**National Patient Safety Alerting System**	**20-Feb-14**	**To be tabled at next CMT**	**20-Aug-14**
MDA/2014/0073	**Peristeen anal irrigation made by Coloplast- Revised instructions for use**	**MHRA Medical Device Alerts**	**26-Feb-14**	**Historic isolated usage limited to ITU, proposal to share through Nursing Newsletter**	**08-Apr-14**

PSA/W/2014/00	Risk of associating ECG records with wrong patients	National Patient Safety Alerting System	04-Mar-14		Lynne Knowles Cardioresp leading, all relevant users communication in preparation	04-Apr-14

From Date: 01/04/2013 00:00 To Date: 27/03/2014 00:00

Response Status:

Reference	Alert Title	Originated By	Issue Date	Status	Response
EFN/2014/12	High Voltage Hazard Alert - NATIONAL EQUIPMENT DEFECT REPORT (NEDEeR) - UPDATE - Schneider Electric ...	DH Estates and Facilities	05-Mar-14	Issued	Acknowledged
NHS/PSA/W/2014/003R	Risks of associating ECG records with wrong patients	NHS England	04-Mar-14	Issued	Acknowledged
NHS/PSA/W/2014/003	Risks of associating ECG records with wrong patients	NHS England	04-Mar-14	Issued	Action Not Required
EFN/2014/11	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION - ABB Low Voltage Fuse Cabinets	DH Estates and Facilities	04-Mar-14	Issued	Acknowledged
EFN/2014/10	High Voltage Hazard Alert - SUSPENSION OF OPERATIONAL PRACTICE (SOP) - UPDATE - Long & Crawford ...	DH Estates and Facilities	03-Mar-14	Issued	Action Completed
EFN/2014/09	High Voltage Hazard	DH Estates and	27-Feb-14	Issued	Action Completed

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	Alert - SUSPENSION OF OPERATIONAL PRACTICE (SOP) - UPDATE - Long & Crawford ...	Facilities			
MDA/2014/007	Peristeen anal irrigation system manufactured by Coloplast Limited.	MHRA Medical Device Alerts	26-Feb-14	Issued	Assessing Relevance
MDA/2014/006	Electrosurgical devices.CUSA CEMâ„¢ nosecones for use with the CUSA® Excel/Excel+ ultrasonic aspi ...	MHRA Medical Device Alerts	26-Feb-14	Issued	Action Not Required

The CMT meeting members should recognise the process as dictated and followed through the *'**Best Practice Policy** Implementation of national alerts, reports and reviews'* and be confident in their role of affirming declarations externally supporting Trust compliance with the alert. With regard to NICE guidance, this same policy is utilised, but currently it is not clear on the role of the Committee structure/CMT in supporting determination or monitoring of Compliance, beyond the work undertaken by the Governance Support Unit's role, and as such, this too will be included in the work as described above to strengthen processes and visibility.

4. The Risk & Control Framework

4.1 *The AGS requires that the Trust describe key elements of the risk management strategy, including the way in which risk is identified, evaluated, and controlled. To explicitly describe the key elements of the quality governance arrangements, including how assurance is obtained routinely on compliance with CQC registration requirements. Explicitly include how risks to data security are being managed and controlled. To include a brief description of the organisations' major risks, including significant clinical risks, how they will be managed and how outcomes will be assessed.*

4.2 Quality Governance Framework / Assurance

The Monitor Quality Governance Framework is an assessment tool for Boards to review their governance arrangement to ensure essential levels of quality and safety are met and to drive forward continuous improvement. The framework sets out 10 key questions underpinning four categories of quality governance. A summative assessment of documented evidence of practice against best practice examples and assigned a risk rating to each of the 10 key questions using the Monitor scale has been carried out on a number of occasions in the second half of the year

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to which this report pertains. Additionally, PWC assessed the Trust as 13 at the end of June 2013 and externally validated a score of 4 at the end of January, illustrating an impressive improvement in the Trust's quality governance processes over recent months. More work needs to be done, and the Executive Team is driving improvement in order to deliver an anticipated score of 3.5, by the end of March and 3 by the end of May. The Company Secretary will ensure the QGF remains a constant focus of the Board to ensure the Trust does not become complacent, and will continue to ensure focus of agendas, Committees and confirm and challenge sessions allows for the continuation of challenge across all domains and that the future iterations of such include time for non-executive leads to carry out further testing of the evidence through continuing the processes of observation and interview.

It is important to note that the evidence used to reach conclusions on our QGF score , and on our compliant status across all mandatory frameworks, and our own effectiveness at managing risk does not solely rely on documents, and reports received internally and so must be triangulated with assurance from:

- External assurance: KPMG and PWC, CQC, NHSLA, commissioner visits, external reviews.
- Internal Assurance: GSU, IAT visits, Board Assurance Framework, commissioners, clinical audit, Audit Committee, performance metrics, service reviews, CIPs, PMO, ward accreditation scheme, walk rounds, governors PQ&E meeting, Quality and aligned Strategies, SI/incident reporting etc
- Audit and Monitoring: Annual Audit plan, Ward to Board, CQC outcome guardians/IAT action plans.
- Management and leadership: responsibilities agreed, policy framework review, CPD, Mandatory training compliance.
- Patient/Carer feedback: F&F, surveys, complaints, whistleblowing.

4.3 Care Quality Commission (CQC) Registration requirements:

Work will have been undertaken by the Executive Director of Nursing to understand and be confident in the Trust's Registration with the CQC to ensure of all the locations at which the Trust provides services that the appropriate CQC registration of each location and for all service activities has taken place. The Trust's 'Statement of Purpose' which is a document required by the CQC on Registration and is required to be updated following any changes to registered locations or activities will make clear, the Trust's current scope of registration and Board members should familiarise themselves with the Trust's statement.

During the period of this report, the CQC's Essential Standards had 28 outcome areas each with specific measures attached. 16 of these outcome areas relate directly to the quality and safety of care and apply to all provider types. The other 12 outcome areas relate to routine day to day management of services. The Board should be clear on how the Trust monitors compliance against all 28 measures and subsequently, how it does the same with regard to the new standards. The monthly and quarterly quality reports have provided the Board with narrative concerning compliance with the standards most directly related to the quality and safety of care.

In order to provide further triangulation of the organisation's compliance against the CQC outcomes directly related to patient care (and there successors), IAT visits and the work of the Outcome Guardians have supported understanding of compliant status and again have featured in the Quality reports and the reports since October 2013 have been scheduled on the Board agenda quarterly to ensure that relevant quarterly reports and focus aligned with the submission of the quarterly self certification to Monitor, enabling detailed challenge at Board prior to signing off the Declaration (self assessment against targets, CQC compliance, Learning Disability compliance, process for revalidation of doctors etc)

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As the 'new' Board improves its ability to triangulate information from discussions with senior staff, reports from Executives to Board, Confirm and Challenge sessions and 'walk-abouts', it should as a consequence be able to compare assessments of compliance in the quality reports with that intelligence and with the data reported to Board regarding 'outcomes' in the form of third party feedback from claims, incidents and complaints in addition to members' own assurance activities as referenced above and thereby be in a strong position to focus questioning and the commissioning of drill down/deep dive reports through the governance committee structure.

In order to be more robustly assured of the effectiveness of compliance and risk management activities at Divisional level, the Board through its committee structures, needs to get closer to the workings and effectiveness of the Divisional and Service Line Clinical Governance Committees in order to be confident that services are clear on shortcomings and have strong plans and support for, recovering those positions.

The July 2013 CQC inspection resulted in five compliance judgements, of which one indicated a 'warning notice' in respect of Outcome 16, *assessing and monitoring of the quality of service provision.* The table below sets out the judgment the Trust received for the outcomes assessed.

2.0 Summary of the CQC findings

Standard	**'Outcome' Judgement**
Care and Welfare of people who use the service	Minor impact to patients
Meeting Nutritional needs	Moderate impact to patients
Cooperating with other providers	Standard met
Cleanliness and infection control	Standard met
Staffing	Moderate impact to patients
Supporting Workers	Standard met
Assessing and monitoring the quality of service provision	Moderate impact '**Enforcement Action'** A 'warning notice' was issued with a specific deadline for meeting the standard by the 31st October 2013
Complaints	Moderate impact to patients

The judgements were issued to the Trust in September 2013 in a CQC formal report. The Trust was revisited on 4th December 2013 to assess the Trusts position against the warning notice. The formal report was published on the CQC website on 3rd January 2014 http://www.cqc.org.uk/sites/default/files/media/reports/RK5BC_Kings_Mill_Hospital_INS1-1085602472_Responsive_-_Follow_Up_03-01-2014.pdf

Like the Keogh follow up visit, the CQC saw evidence of demonstrable improvements, but acknowledged that in some areas more time was required to embed or audit against compliance. Board has monitored progress monthly since Q3 with regard to Keogh and CQC.

4.4 Internal Audit (360 Assurance)

The Audit plan for 13/14 was developed in line with the mandatory requirements of the NHS IA Standards and EMIAS (now 360 Assure) have worked with the Trust to ensure the plan was aligned to our risk environment. In line with the Internal Audit Work Plan full scope audits of the adequacy and effectiveness of the control framework in place are complete or underway for the following areas for the twelve months from April 2013 to March 2014.

Audit Title	*Report to be Issued as Final (Quarter)*	*Current Status*	*Assurance Level Provided*	*Date Reported to Audit Committee*
Financial Management				
Key Financial Systems	Q4	Draft Report		
Pay Expenditure	Q4	In Progress		
CIP/QIPP/Transformation	Q3	Complete	Significant	16th January 2014
Financial Management and Reporting	Q4	Planning		
Contract Management – Healthcare Procurement	Q4	Work In Progress		
Charitable Funds	Q4	Work in Progress		
IM&T				
Information Governance & Data Protection	Q3	Complete	Significant	16th January 2014
Freedom of Information Act Compliance and Management of Subject Access Requests	Q2	Complete	Limited	16th January 2014
Information Management & Data Quality	Q3	Deferred to 2014/15		
Ward Assurance Dashboard	Q4	Planning		
Quality Account – Data Quality Review	Q4	In Progress		
Performance				
Performance Management Framework	Q4	In Progress		
Newark Hospital Strategy	Q4	Draft Report		
Clinical Quality				

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Audit Title	Report to be Issued as Final (Quarter)	Current Status	Assurance Level Provided	Date Reported to Audit Committee
CQC Compliance Review	Q4	Draft Report		
CQC Corporate Assurance				
Incidents Management	Q2	Complete	N/A	25th October 2013
People Management				
Sickness Management	Q1	Complete	Significant/ Limited	25th October 2013
Bank and Agency	Q4	In Progress		
Annual Leave Management	Q2	Complete	Significant/ Limited	25th October 2013
Recruitment and Selection	Q2	Complete	Significant/ Limited	25th October 2013
Governance, Risk & Legality				
Communications Strategy	Q3	Complete	Limited	16th January 2014
Risk Management	Q4	In Progress		
BAF and HOIA	Q4	In Progress		
Review of Newton Europe Contract	Q4	Draft Report		

(Assurance level - sig / limited means that the opinion has been split – IA has given significant in part (e.g. for sound procedures) but limited for the other part of the scope (for example adherence to procedures).

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Recommendations made for all the above audits are followed up by Internal Audit to ensure that all recommendations are sustainably implemented within the organisation. Following their review, any remaining unimplemented recommendations are escalated to the Audit Committee and the Company Secretary has now included an escalation report within the Trust Management Board agenda to be presented by the Chief Financial Officer to ensure escalatory actions are taken by the appropriate Executive Lead if remedial actions are not addressed expediently.

4.5 External Audit (KPMG)

External Audit carried out the required audit of the 2012/13 annual report and accounts and the quality accounts.

As per the requirements of Monitor's Code of Governance for Foundation Trusts, section F3.5, the Audit & Assurance committee will need to keep under review the need to market test both the internal and external audit providers to the Trust on an appropriate cycle. The KPMG

contract is for 3 years from November 2012 (i.e. starting with 2012/13 accounts), with an option for 2 further years. The contact includes Quality Accounts and Charitable Funds accounts.

The Internal Audit contract with 360 Assurance (which was still EMIAS at the start of the financial year) is a rolling contract, which doesn't get renewed as such, but a daily rate is agreed by a consortium for each year. Recently it appears we also have a clause in the contract that shares the liability between consortium members for potential redundancies should any members pull out of the contract. EMIAS have provided the Trust's Internal Audit function since before the Trust became a Foundation Trust in 2007/08.

The Board through delegated authority to its committees, has reviewed the effectiveness of the organisation's system of internal control, performance reporting, policies and procedures, and received exception reports where appropriate, much of which is evidenced through the detail in this Board Assurance Statement. The Board has continued to strengthen its assurance function through its Audit Committee which throughout the period of the report has monitored and reviewed the direction of the Trust's internal assurance work, the work of Internal and External Audit and where necessary commissioned additional assurance activity. This has ensured that there has been a system for the regular review of the effectiveness of its internal controls and the Committee has, through exception reports to the Board, satisfied Board on the effectiveness of its internal controls, or on actions to address shortcomings in those controls.

Future Board Assurance Statements will include a summary of the work of the Board committees along with a sense of the work of the Operational Governance Committees of TMB in connection with their accountabilities concerning the management of risk and the effectiveness of the control environment.

4.6 Board Assurance Framework & Risk Management

The Board has responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives and which manages risk to a reasonable level. The Trust's Board Assurance Framework (BAF) acts as a reference document for the Board of Directors to support evidence of good governance. The risks captured on the current BAF emanated from work with KPMG at the beginning of the financial year and a review of the BAF in readiness for 14/15 will start on 3rd April with a Board Development & Training Session on risk.

The Board Assurance Framework holds the following key information:

- Trust's Principal Objectives where there are significant risks to its attainment.
- Trust's Principal Risks which are based on top down (Board of Directors / Committees) and bottom up information (Risk Registers etc.).
- Links to relevant legislation / regulation.
- Links to Key Performance Indicators e.g. national targets.
- Sources of assurances based upon evidence around compliance with, and effectiveness of, the controls to manage risk.
- Lead(s) (both Executive and Non-Executive Directors) responsible for assuring the adequacy of assurances.

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- Control / assurance gaps threatening the achievement of a standard / target / objective and any recommendations / conditions arising from audits and inspections, staff and patient surveys etc.
- Action and Timescales to address identified gaps in controls / assurances.

The BAF for 2013/14 was developed in collaboration with Board members and KPMG at the beginning of the financial year. Updates on the Principle Risks have on numerous occasions been presented to the Risk Assurance Committee and to Board and have been discussed and assurances have also been sought on the effectiveness of controls through Exec Team Meeting and latterly through the Finance & Performance and CG&Q Committees and risks have been escalated during the year for inclusion in the BAF. A dedicated Risk & Assurance Committee took place in November to consider the risks associated with the October Strategic Improvement Plan, and again consequential changes to the BAF were made to reflect the changing strategic risk profile and control framework. As previously stated, the BAF will be revised again for 14/15.

The Company Secretary is progressing work for introduction in April to strengthen the depth of information presented that will enhance the provision of assurance directly from an Executive Director that they are confident objectives are safeguarded by a strong and effective suite of controls, and the Audit & Assurance Committee will be the custodian of the BAF and make determinations concerning the effectiveness of the control environment. A Board Assurance Report will be introduced which each lead executive will present to the Committee across the year, and contained within this process, will be the creation of a lead non-executive and a lead committee role for each risk to ensure there is a system for the regular review of the effectiveness of internal controls as well as 'confirm and challenge' through the TMB Committee structures of each BAF report prior to its presentation at the Audit and Assurance Committee.

For 2014/15 the Company Secretary will explore the use of the Datix system for hosting the BAF document. The rational for this move being to ensure the BAF is hosted on the integrated risk management system used by the Trust to enable easy cross referencing between the BAF, risk assessments and risk registers thereby further enhancing its robustness. The annual review of the Trust's Assurance Framework by the Internal Auditors is underway and the outcome will be reported to the Audit and Assurance Committee in April/May.

During Q3 onwards the Risk and Assurance Committee has driven a marked improvement in the quality of the Divisional and Corporate high risk registers and robust debates have taken place resulting in the strengthening of controls (eg Decontamination; retained estate/capital programme; mortality etc.). Significant work has been undertaken with the Divisional senior teams to develop the Corporate Risk Register, which has been presented to the last 2 meetings of the Risk Assurance committee evidencing through this process and the review of Divisional Risk Registers, the improvement in the risk management framework across the Trust. Further improvement activity will take place in Q1 of 14/15 to improve the action plans that support closures of control/assurance gaps. The PWC external assurance of the Trust's delivery against the Jan13 action plan (sent to Monitor in October13) cited that the Trust had completed its action with regard to structuring the committees in order to establish a structure which seeks assurance over risk and quality for the Board and confirmed we 'had delivered the majority of actions, citing only the training of Divisional and Service Management and the Corporate Risk Register as areas requiring further progress. Actions for both of the latter have progressed significantly since the PWC final report.

The Company Secretary introduced the NED Confirm and Challenge process in Q3 which has been a constructive stimulant in the development of the NEDs understanding of the way that quality and risk management is understood and embedded across the Trust and the sessions have provided the NEDs with reasonable assurance in order to approve positive movements in the QGF score through demonstration of the application of a much stronger control environment thereby better safeguarding delivery of the Trust's objectives. The

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ToR of each Board Committee (and TMB) were approved in December and are specific with regard to responsibilities regarding the management of Risk. Finally, during the year, maternity services achieved LEVEL 2 status, a significant part of which requires the evidencing of effective risk and control frameworks.

The full BAF for 2013/14 is included as part of this agenda item. Future BAS reports will also include a holistic picture of the documents, policies and strategies approved by the Board relevant to the process of systematic review of the effectiveness of controls and relevant to self-assessments of compliance which have been considered and approved by the Board across the financial year

The Trust recognises the strategic role of Risk management in underpinning the organisation's reputation and performance. Successfule implementation of the new Risk Management strategy will be key to delivery of organisational objectives in relation to governance and controls assurance and the training is already spreading a wider understanding of its importance. In addition, the embedding of effective Risk Management systems and the development of a positive learning environment support improvement of services and delivery of Trust priorities in all areas and the new Board Committees will be instrumental in continually testing control effectiveness.

Decision making about Risk Management priorities within the Board Governance Committees was informed by a range of information including:

- PWC review and external assurance
- Prioritised risk register information from Divisions to the RACommittee
- Reports from incidents, complaints and claims systems to CG&Q Committee/Board
- Issues highlighted in structured Directorate and Department risk reviews and ad hoc feedback
- Issues highlighted by the Governance Support Unit via CMT

4.8 Standards of Business Conduct

Following the approval of a revised version of the Trust's Standards of Business Conduct at the Audit and Assurance Committee on 16th January 2014, communications promoting the SBC to staff will need to follow and advice on circulation and training is currently being taken via the Local Counter Fraud Service and final decision on this will be reached in March 2014.

Raising Concerns: Whistleblowing Policy: This was approved by the Board of Directors at its meeting in November 2013. It is on the Trust's internet site for easy access and members of the Board have had training in February. The policy is supported by a comprehensive training programme for managers and also is now a standard part of the Trusts Leadership and Management rolling programme of courses.

Declarations in relation to the Trust's Standards of Business Conduct (SBC) continue to be made mainly in relation to sponsorship and gifts, and an annual register is maintained for which a Board report will be presented at the April Board of Directors.

The Company Secretary has reviewed the process for the register of declarations of interest used in the Trust's procurement processes and in order to tighten up the process is liaising with the Strategic Head of Procurement and will align the documented guidance with a review of the Board's and CoG's declaration. No declarations have been made regarding the contracts the Procurement Department has been working on during the year to which this BAS pertains.

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4.9 Counter Fraud work undertaken during the period - the annual work plan for 2013/2014 has proceeded as agreed when the plan was approved by the Trust Counter fraud work undertaken during the period has included

Counter Fraud activities during 2013/14 include: 2013/14 information reports opened = 11 2013/14 investigations commenced = 2 2013/14 information reports closed (no fraud) = 10 2013/14 investigations closed = 0	• CF workplan developed in agreement with the CFO; • Development, publication and circulation of the counter fraud newsletter, Fraudulent Times; • Development and delivery of Counter Fraud eLearning modules; • Staff survey; • Provision of ad hoc advice; • Proactive detection exercise involving procurement commenced in March 2014.
Reports provided	• Regular progress reports provided to the CFO and Audit Committee; • Ad hoc reports produced to summarise individual pieces of work as appropriate (for example, staff survey report); • Closure letters/concluding reports produced for each completed investigation.
Prevention work	• Recommendations to address weaknesses identified during the course of investigations are referred to the Trust for consideration; • Exception reports are produced for the Audit Committee where recommendations are not adopted or where corrective action isn't implemented; • Review and refresh of existing polices and development of new policies; • Circulation of intelligence bulletins/local alerts/scam warnings

- No instances of management override of controls have been identified by the LCFS;
- No instances of actual, suspected, or alleged fraud, including misconduct or unethical behaviour related to financial reporting or misappropriation of assets have been identified by the LCFS; and
- No risks have been identified by the LCFS to suggest that the financial statements may be materially misstated due to fraud

4.10 Information Governance

The Chief Financial Officer has undertaken the role of SIRO (Senior Information Risk Owner) for the year of this Board Assurance Statement. As such she remains the Chair of the Information Governance Group.

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The Information Governance Toolkit submission has been included within the Board of Directors' work plan to ensure line of sight at Board of this submission in December and in the month of the Board declaration of compliance in March. The IG toolkit is a performance tool produced by the Department of Health (DH) and now hosted by the Health and Social Care Information Centre (HSCIC). It draws together the legal rules and central guidance relating to IG and presents them in one place as a set of information governance requirements.

Oversight and Assurance: - The13/14 IG forward Work plan identified accountable officers within the Trust for each standard to be achieved, with the expectation that performance against standards will be monitored and supported via the IG Group on an on-going basis throughout the year. It maps the key tasks that need to be carried out until the March 2014 submission.

Sherwood Forest Hospitals NHS Foundation Trust's Information Governance (IG) assessment report overall score for 2012/13 was 72%. This was graded as "Green" – "Satisfactory". There is a requirement for all IG Toolkit standards to achieve Level 2 or above for the Trust to be graded as green. We have therefore set out to achieve a score of 74% in 2013/2014. The Trust is expecting to surpass this by achieving 78% by submission on 31st march 2014

In order to achieve and maintain this standard the Trust has set out to do the following:

- Ensure IG remains a mandatory annual training requirement for all staff
- Build on the establishment of Information Asset Owners and Administrators to ensure that there are responsible officers in each Division to support the embedding of IG principles within the Trust
- Develop a formalised programme of information asset risk assessment, providing assurance from each Division that information assets are actively reviewed

Out of the 45 standards so far we have achieved 7 new level 3's and maintained 7 previous level 3's. All of the other standards are on course to achieve level 2.

The IG team has also produced the following:

- A new information asset register
- Identified information flows in all areas
- Identified information risks for the Trust

Progress against the standards is monitored at the Information Governance group.
An IG improvement plan is to be provided to the IG group at the meeting in March. This plan will make recommendations to the Trust for continued improvement across all IG standards

- Further improvements identified.
- For each standard to have one lead responsible for the identification, collation and uploading of the evidence required for the toolkit.
- For each Information asset owner to be required to report progress against toolkit requirements to the IG group on a quarterly basis
- Developing a formalised programme of information asset risk assessment, providing assurance from each Division that information assets are actively reviewed

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- For all staff to have mandatory annual IG training

There has been one serious incident relating to information governance in the past year – reported as a 'near miss'. The SI has been logged on the IGtoolkit (which automatically sends the incident to the DoH and the ICO) This is what was reported:

The Trust has been made aware of a near miss incident where the storage provision on the former ward 3 were not meeting expected security, control, access, cataloguing or basic health and safety requirements.

The area is now secured with a swipe card entry system with access only being given to a select number of people. All notes are in the process of being reviewed, catalogued and if necessary destroyed in accordance with the Trust destruction policy. Health and safety issues identified have been dealt with and either removed totally or safe systems of work have been put in place.

Training: The last reported training figures to the beginning of February were that 3960 staff had been trained in this financial year: (Online 2667; Face to face 1293)

The Board will need to maintain a focus on achievement of Information Governance in order to ensure as a minimum we maintain level two status (in accordance with Monitor requirements).

4.11 External Reviews

Following approval and implementation of the External Recommendations Policy, future BAS reports will include a holistic view of the external agency visits and outcomes that have taken place across the period. The Board is award of the outcome of the reviews conducted by KPMG into financial governance (positive assurance received in year), by PWC into Board and Quality Governance (positive assurance received in year, though QGF just above requirement to be at 3.5) and by the CQC with regard to Warning Notice (now minor concern) and remaining outstanding actions as referenced in the CQC section of this BAS; and finally is aware of the positive follow up in December 13 by the Keogh team and Board will continue to track progress such that all actions are 'fully assured' in a timely manner. The CQC will be inspecting the Trust week commencing 21st April, and members of the Board and Executive team are engaged in numerous activities to obtain assurance of progress, with the PMO playing a significant role over recent months in gathering and quality assuring evidence of such.

5. Review of Economy, Efficiency and Effectiveness of the Use of Resources

5.1 The work of the Board and its committees have facilitated the organisation's effective and efficient operation, albeit in very challenging times, by enabling it to respond appropriately to significant business, operational, financial, compliance and other risks to achieving the Trust's objectives. This has included the continued safeguarding of assets from inappropriate use or from loss and fraud and ensuring that liabilities are identified and managed. The realisation of regulator interventions (significant breach, warning notice, special measures) has led to a number of changes to the control environment along with a risk based approach to the assurance attached to evidence provided to PMO to assert completion/compliance with action plans to deliver regulatory requirements and to improve the quality of governance and finance..

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5.2 A tight PMO focus will need to continue with regard to CIP delivery and the Executives are driving continued work around transformation which will from here on in, be fundamental to realising the inevitable spend reductions in order to meet the cost reduction strategies required across the next three-five years.

External reviews undertaken by PwC ,EY and KPMG were received regularly by the Board and discussed in detail in the run up to the October Monitor submission (to include update on Discretionary Requirements). The Board will need to monitor sustained change following delivery against the required actions identified in PWC and KPMG's action plans. Board members will need to agree the submission of the 14/15 Annual Plan on 18th March, with the associated assurances regarding deliverability and quality impact to be analysed through the Corporate Governance Statement Board declaration process (June submission)

5.3 In view of recent events, the current pace of change and economic challenge faced by the organisation it is imperative that the Board continues to closely monitor progress and commissions the appropriate level of assurance to satisfy itself that risk is being managed effectively and the Audit and Assurance committee feel confident that significant progress is being made in this regard and with delivery of the savings outlined in the Annual (improvement) Plan.

5.4 **Code of Governance**

Part of the Annual Report submission also obligates against the 'comply or explain' principal, that the Trust explains reasons for any non-compliance with Monitor's Code of Governance and illustrates how its actual practices are consistent with the principle to which the particular provision relates. When the draft AGS goes to Audit and Assurance committee in April, the Code of Governance statements will be included for consideration but it will be reported that during the course of the year, the Board considers Monitor's *"NHS Foundation Trust Code of Governance"* has been complied with, including the identification of a senior independent director (SID) in December 2013 by the Nominations Committee of the Council of Governors, when Dr Gerry McSorley was identified as the SID. It will be explained that the SID has continued in this role throughout the remainder of 2013/14.

6. Significant Control Issues

The Trust was found to be in significant breach of its Terms of Authorisation in September 2012, and subsequently in breach of its licence under the new legislative regime which commenced on 1 April 2013

There have been no significant control issues in the last 12 months that have been indicative of systemic[1] deficiencies in the control environment. Actions have been taken where less substantial weaknesses have been identified and are identified within this Statement.

Since being found to be in significant breach in 2012 the Trust has developed a generally sound system of internal control that has developed further with the substantive appointments to Board finally completed at the end of Q3. The Board is however, albeit through monthly financial submissions, still being monitored closely by Monitor due to its planned and previous financial deficit status and has during the period of this BAS received confirmation that the Trust has not satisfied its Discretionary Requirements with respect to Financial Governance and Quality Governance. However, subsequently, the Trust has received affirmation from KPMG of completion of the only 2 outstanding actions with regard to Financial Governance, and following the PWC confirmation of the Trust's achievement of a QGF score of 4 at the end of January,

[1] Board of Directors might wish to agree the following definition of 'systemic' - '*widespread and universal breakdown in the control regime' [during the year]*

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the Board will be approving a recommended score of 3.5 at its March meeting, which now satisfies that element of our Discretionary Requirements.

The Trust has highlighted risks to the delivery of its planned deficit, including the impact of the Keogh Review, particularly on staffing, operational income risks including activity in excess of the marginal rate non-elective threshold and CIP delivery risk. Monitor expects the Trust to mitigate these risks where it is possible to do so without detracting from quality of service, to ensure that the Trust meets Monitor's Discretionary Requirement to deliver its five-year financial plan. The Board will, over the coming months, progress project management of cost improvement plans (CIPs) and monitoring arrangements in order to ensure financial recovery and return in the medium term to a sustainable position not withstanding the PFI funding situation.

The Audit and Assurance Committee/Board is invited to consider whether any report it has received, such as serious incidents, claims, complaints, audits/inspections or surveys, constitute a significant control weakness in order that the Annual Governance Statement as part of the Annual Report reflects the position as agreed by Board members.

7. Actions planned over the next six months

The next six months will continue to be challenging and amongst many activities will include significant work regarding the following:

- Annual Plan 2013/14 and how this will align with Recovery Plan submissions to Monitor.
- Close management of CIPs to include Divisional and Corporate cost reduction schemes through PMO (to include CQUINs/QIPP).
- Sign off of the Contract with the Trust's principal commissioner
- Board agreement to the 2015/16 cost improvement target (and QIA) and monitoring process along with the timely planning of the business planning cycle
- Continuing pressures to do more with less, requiring significant cost reduction plans including assurance of deliverability and protection of quality to ensure not diluted to unacceptable levels – with particular consideration necessary to the systems of assurance upon which the Board will rely
- Progression of short, medium and longer term priorities in accordance with the full Recovery Plan milestones along with the agreement to metrics to monitor progress and achievements against recently approved strategies (Quality, OD& Workforce, IT, Procurement etc)
- Continuing tight focus on reductions in admissions and length of stay and building on self-care and care in the community .
- Continuing work to gain PFI support – working with Monitor, LAT and CCG.
- Continuing with the CCG to build on relations and to integrate Better Together
- Implementation of Quality for All – vision and values
- CQC planned visit w/c 21st April – and the impact of that pre and post visit (including the potential for lifting of special measures)
- Annual Report submission along with associated corporate governance statements, Quality Accounts and Remuneration Reports

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- Progress with Business Intelligence to ensure better understanding of ‘outcomes’ and concerted focus on Transformation to support service redesign that by default will galvanise 15/16 CIPs and enable pathway redesign including across the multiagency landscape
- Roll out of an Operational Assurance Framework that places responsibility for assuring compliance firmly with the Clinical Directors as the heads of service delivery units.
- Continuation of implementation of actions to ensure sustainability following the review of the implications for the Trust re the publication of the Francis Report, Keogh, PWC etc. alongside further enhancements to the assurance processes regarding the new CQC standards

The Board will need to ensure its information and reports support understanding and assurance of safe care through intelligent and transparent performance information of the quality of both inputs and outputs.

The financial position of the NHS in general continues to be very challenging and locally there can be no doubt that the Trust is feeling the pressure of central initiatives to reduce costs (e.g. tariff changes, caps on growth, impact of CQUINS). The Trust has already introduced a plan regarding a range of short, medium and longer term proposals to reduce costs and overheads and realign service delivery. All will be closely monitored by Board of Directors and the success of these will return the Trust to a more viable financial position.

The Board will continue to focus attention on risk and performance across these key areas and will need to ensure its confidence is strengthened in the systems and processes that assure the Board of the effective management of risk and the attainment of objectives.

Finally, there have been significant changes in the Board of Directors over the preceding 12 months, in both executive and non-executive leadership, and it will be critical to the success of the organisation that these changes strengthen the effectiveness of the Board and the Executive team in achieving the Trust’s objectives and in evidencing strong governance and robust plans to recover and in the fullness of time sustain commercial/financial stability.

8. Action Required

The Board of Directors is asked to consider if this Statement substantiates the evidence that will be required to support signing of the Annual Governance Statement (AGS) by the Accounting Officer on behalf of the Board, at the Annual Report submission stage.

The Board of Directors is invited to continually consider the detailed content of the six-monthly Board Assurance Statements in assuring it of the credibility and robustness of its self-assessments to the Regulators and is reminded of the importance of deliberations regarding the seriousness in terms of ‘significance’ of control failures / weaknesses in support of the AGS submission as part of the Annual Report (as detailed in section *6. Significant Control Issues*).

A draft of the Annual Governance Statement for inclusion in the Annual Report will be presented to the April Audit who will support or otherwise its adoption by the Board of Directors for inclusion in the Annual Report.

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